DEPARTMENT OF HEALTH & HUMAN SERVICES

Food and Drug Administration

5162

Chicago District
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Chicago, Illinois 60606
Telephone: 312-353-5863

February 8, 2001

WARNING LETTER
CHI-19-01

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

William H. Portman, President
LifeSource Blood Services,
1205 North Milwaukee Avenue
Glenview, IL 60025-2498

Dear Mr. Portman:

During an inspection of your licensed blood center, which was conducted from September 18 through October 13, 2000, investigators Jeanne Morris and Humera Khan documented violations of Section 501(a)(2)(B) of the Federal Food, Drug, and Cosmetic Act (the Act), and the Current Good Manufacturing Practice (CGMPs) regulations for blood and blood components [Title 21, Code Of Federal Regulations, Part 600-680 (21 CFR)]. These deviations were cited on the Form FDA 483, List of Observations, issued to you on October 13, 2000. The deviations reported on the FDA 483 included:

> The conclusions made following manual investigations by LifeSource personnel following the [redacted]/LifeSource (LS) donor database merger were not supported by documentation [21 CFR 606.160(a)(2)]. For example:
>
> > Donor [redacted]. (permanent [redacted] deferral) and [redacted]. (no LS deferral) had identical social security numbers. Following unsuccessful attempts to contact the donors, the LS reviewer concluded these were unique individuals and the files were not merged. [redacted]. remains an eligible donor.
> >
> > Donor [redacted]. (permanent deferral LS) and [redacted]. (no [redacted] deferral) were listed as having the same social security number. Following unsuccessful attempts to contact the donors, the LS reviewer concluded that the social security number (SSN) assigned to [redacted]. was incorrect and the file was removed from the database.
> >
> > Donor [redacted]. (permanent deferral [redacted]) and [redacted]. (no LS deferral) were listed with the same social security number. No records could be located that indicate whether the donor was contacted. However, a decision was made by LS personnel that these were the same individuals and the files were merged. The SSN was retained for the [redacted] file and the file for donor [redacted]. was removed from the database.
>
> Donors with permanent deferral codes applied by [redacted] are reentered into the LifeSource Donor eligible donor pool without adequate documentation to support these decisions [21 CFR 606.160(b)(ii)]. For example:

Donor [redacted]. was permanently deferred by [redacted]. [redacted] faxed information to LifeSource noting the donor's repeat reactive EIA for HTLV on a single date. Based on this information, LifeSource reentered this donor. LifeSource did not obtain the donor's complete testing history from [redacted]. A review of the patient's history during the FDA inspection revealed the donor tested repeat reactive for HTLV by EIA on multiple [redacted] donations, which should have prevented any reentry of this donor. As a result of this error, LifeSource had to recall several blood components.

Data deferral codes are added or deactivated without supporting documentation to explain these changes [21 CFR 606.160(b)(ii)]. For example:

Donor #[redacted] with deferral L12 (HIV, RR, WB, NR) was added on 7/23/93, deactivated on 7/27/93, and readded on 7/27/93.

Donor #[redacted] with deferral L14 (HIV RR, WB Confirmed) was entered on 6/28/91, with a status of deactivated, entered on 7/26/93, with a status of deactivated and re-added on 7/27/93. Also, the 69 deferral indicating this donor is a confirmed possible HIV is missing from this donor's deferral history record.

Data deferral codes and/or dates do not correspond to donor's history or test results [21 CFR 606.160(b)(ii)]. For example:

For donor #[redacted] a Health History Permanent (HHP) deferral was added on 7/3/91. There is no information why this deferral was added in that test data from this date revealed all virology assays were non-reactive and health history was acceptable. Further review revealed that this donor tested repeat reactive for HCV in 1990.

For donor #[redacted], a Health History Temporary (HHT) was entered on 10/20/91, for an unacceptable pulse. The donor's deferral history shows that the donor was deferred until 6/8/92. The 10/20/91 donation does not exist in the donor history record.

Failure to have available records that identify potential duplicate donors following the LifeSource/[redacted] donor database merger. For example, when our investigators requested the reports used by LifeSource to assess the donor database integrity to identify potential duplicate donors, they were told that LifeSource generated two reports that identify donors with exact matches on first and last name, and exact matches on social security number. The first report (name match) could not be located by LifeSource and approximately 117 pages were missing from the second report (SSN match) [21 CFR 606.160(e)].

Failure to follow written procedures covering the documentation and investigation of product non-conformance reports [21 CFR 606.100(b)]. LifeSource procedure SOP 01.300 requires that the corrective action plan be completed within three weeks of the date the non-conformance is discovered, and sent to Quality Assurance for review and

approval/revision. The inspection revealed that LifeSource is not meeting that requirement. For example, in July 2000, approximately [redacted] Process Improvement Form (PIF) reports of non-conformance were submitted. As of 9/22/00, only [redacted] of these PIF's were completed.

Investigations and corrective actions initiated as a result of errors reported on PIF reports are incomplete and do not assure such errors will be prevented in the future [21 CFR 606.170(a)]. For example:

PIF [redacted], dated 8/29/99, notes a non-reactive EIA test was obtained on a sample which was positive for HIV by Western Blot at two different laboratories. This investigation eliminated the possibility of a sample mix-up, but does not address the discrepant EIA test result. As of 9/21/00, the PIF remained open.

PIF [redacted], dated 5/8/00, notes segments were leaking on units collected from a mobile drive. The PIF associates the problems with units [redacted] through [redacted]. The investigation addresses a possible Hematron failure, but does not address the potential for bacterial contamination of the products. Components from the units identified on this PIF were released for transfusion. As of 9/21/00, this PIF has not been reviewed by QA.

PIFs generated by the Donor Services Department show continuing errors with donor registration, donor screening and product collection. For example:

In March 2000, approximately [redacted] errors occurred. Approximately [redacted] of these errors were not detected until the third independent review was completed.

In May 2000, approximately [redacted] errors occurred. Approximately [redacted] of these errors were not detected until the third independent review was completed.

In July 2000, approximately [redacted] errors occurred. Approximately [redacted] of these errors were not detected until the third independent review was completed.

In August 2000, approximately [redacted] errors occurred. Approximately [redacted] of these errors were not detected until the third independent review was completed.

Failure to maintain and follow written procedures [21 CFR 606.100(b)]. For example:

SOP 23.302 requires surveillance assertion codes be added to the files of donors implicated in cases of Transfusion associated AIDS that have not been cleared by subsequent testing. This procedure was not followed in two of the two cases reviewed during the inspection.

SOP 03.500 addresses the 100% review of all Blood Donation Records to assure these records are complete and the products collected from ineligible donors are not released. This SOP fails to define who is responsible for adding a deferral code to a donor's file if an ineligible donor is drawn.

There is no written procedure that defines the criteria used when merging the [redacted] donors with deferrals. SOP 06.501 requires that Nucleic Acid Tests for HIV and HCV be 100% reviewed by a second person to assure reporting errors are prevented. The investigators selected one day (9/16/00) of NAT HIV and HCV testing at random for review and it was found that only select data was reviewed by the second individual and not every result as required by the SOP.

Failure to follow validation procedures for the [redacted] computer software validation plan in that all defined donor deferral assessments were not completed. The validation plan used to determine donor deferral conversion required that 10 donors be evaluated for each deferral class assertion. Of eight HTLV assertions reviewed by our investigators, four did not meet this criteria [21 CFR 606.100(b)]. For example:

For the LT5 assertion, [redacted]r donors were tested,
For the LT4 assertion, [redacted]t donors were tested,
For the LT1 and LT9 assertions [redacted] donors each were tested.

Failure to standardized and calibrate equipment used in blood processing on a regularly scheduled basis [21 CFR 606.60(b)]. For example, the [redacted] irradiator, that has been in use at your facility since 1993, has a timer which was not verified or calibrated until 8/21/00.

The above identification of violations is not intended to be an all-inclusive list of deficiencies at your facility. It is your responsibility to assure that all blood and blood components produced and issued by your firm are in compliance with the Act and the cGMP regulations. You should take prompt action to correct these violations. Failure to correct these violations may result in administrative and/or regulatory action without further notice. Such actions includes license suspension and/or revocation, seizure and/or injunction.

We acknowledge receipt of your letters dated November 30, 2000, December 22, 2000, and January 3, 2001, submitted in response to the FDA 483, List of Observations, issued to and discussed with you by investigators Morris and Khan. You submitted a progress report in your January 3, 2001 letter, and the report indicates that LifeSource has completed a number of corrective actions or it provides an estimated completion date for a FDA 483 observation. Those actions you indicate have been completed will be verified in our next inspection.

We request that you notify this office in writing, within 30 working days of receipt of this letter, of specific steps you have taken to correct these violations. You may reference the information provided in your earlier letters to this office in this response. If you would like to have a meeting to discuss the preventive action plan you've discussed, as well as your response to this Warning Letter, we would be glad to meet with you.

Your reply should be directed to George Bailey, Compliance Officer.

Sincerely,

\s\
Raymond V. Mlecko
District Director